CH.	Sect.	Pg.	December 2005 Revision
NA	NA	Title Page	Revised date changed
CH 2	NA	2-3	Revised Regulatory Requirement CMS "F" Tag
CH 2	NA	2-27	Rehabilitation Plus Extensive Services to middle of paragraph
CH 2	NA	2-29	Rehabilitation Plus Extensive Services to last column for OMRA
CH 2	NA	2-31	Rehabilitation Plus Extensive Services to 8. OMRA definition
CH 2	NA	2-36	Rehabilitation Plus Extensive Services to 2nd bullet
CH 2	NA	2-39	Rehabilitation Plus Extensive Services to 2nd paragraph for combining assessments
CH 3	NA	3-3	Changed website address to read http://cms.hhs.gov/quality/mds20
CH 3	T3	3-223	T3. Case Mix Group a. Medicare Change 44 Group Version 5.12 to 53 Group Version 5.2 Change 44 RUG-III groups to 53
CH 3	W1	3-240	Replaced W1 with new language
CH 3	W	All	Replace Section W in its entirety, due to changes in pagination.

	Appendix	Page	December 2005 Revision
	A	ALL	To print Appendix A, go to RAI User's Manual by chapter and print Appendix A in its entirety.
		6	Changed 7 hierarchical groups to 8 to Hierarchy definition. Added Rehabilitation Plus Extensive Services to Hierarchy definition
		9	Added Rehabilitation Plus Extensive Services to OMRA definition
		10	Updated the 2 URLs for Program Memos and Program Transmittal Corrected verb tense in PPS assessment definition from plural to singular (change are to is)
		12	Added 53 to the RUG-III definition as indicated
		14	Added CBSA and added CR.
		15	Added therapist to OT & PT acronyms; added Pub. 100-1, Pub. 100-2, Pub. 100-4, Pub. 100-7, Pub. 100-8, Pub. 100-12 to list; added SLP to ST

Centers For Medicare & Medicaid Services

Revised

Long-Term Care Facility Resident Assessment Instrument User's Manual

Version 2.0

December 2002

December 2005

Section 2.2 of this chapter examines each of the OBRA assessments and provides detailed information on the completion requirements. The following table summarizes the different types of federally mandated assessments.

TYPE OF ASSESSMENT	TIMING OF ASSESSMENT	REGULATORY REQUIREMENT CMS "F" TAG
Admission (Initial) Assessment (Comprehensive)	Must be completed (VB2) by the 14th day of the resident's stay.	42 CFR 483.20 (b)(2)/F 273
Annual Reassessment (Comprehensive)	Must be completed (VB2) within 366 days of the most recent comprehensive assessment.	42 CFR 483.20 (b)(2)(iii)/F 275
Significant Change in Status Reassessment (Comprehensive)	Must be completed (VB2) by the end of the 14th calendar day following determination that a significant change has occurred.	42 CFR 483.20 (b)(2)(ii)/F 274
Quarterly Assessment (State mandated subset or MPAF)	Set of MDS items, mandated by State (contains at least CMS established subset of MDS items). Must be completed every 92 days.	42 CFR 483.20 (c) /F 276
Significant Correction of a Prior Full Assessment	Completed (VB2) no later than 14 days following determination that a significant error in a prior full assessment has occurred.	42 CFR 483.20(f)(3)(iv)/F 287
Significant Correction of a Prior Quarterly Assessment	Completed (R2b) no later than 14 days following determination that a significant error in a prior Quarterly assessment has occurred.	42 CFR 483.20(f)(3)(v)/F 287

The MDS is also completed for the Medicare Prospective Payment System. The Medicare schedule is discussed in detail in Section 2.5

2.2 Required OBRA Assessments for the MDS

ADMISSION ASSESSMENTS

The Admission assessment is a comprehensive assessment for a new resident that must be completed within 14 calendar days of admission to the facility if:

- this is the resident's first stay,
- the resident has just returned to the facility after being discharged prior to the completion of the initial assessment, or
- the resident has just returned to the facility after being discharged as return not anticipated.

The 14-day calculation includes weekends. When calculating when the RAI is due, the day of admission is counted as Day "1". For example, if a resident is admitted at 8:30 a.m. on Wednesday

2.5 The SNF Medicare Prospective Payment System Assessment Schedule

Nursing facilities will assess the clinical condition of beneficiaries by completing the MDS assessment for each Medicare resident receiving Part A SNF-level care. The MDS must be completed in compliance with the Medicare schedule as shown in the chart below.

Medicare MDS Assessment Type	Reason for Assessment (AA8b code)	Assessment Reference Date	Assessment Reference Date Grace Days+	Number of Days Authorized for Coverage and Payment	Applicable Medicare Payment Days
5 Day	1	Days 1-5*	6 - 8	14	1 through 14
14 Day	7	Days 11-14	15 - 19	16	15 through 30
30 Day	2	Days 21-29	30 - 34	30	31 through 60
60 Day	3	Days 50-59	60 - 64	30	61 through 90
90 Day	4	Days 80-89	90 - 94	10	91 through 100

*If a resident expires or transfers to another facility before the 5-Day assessment has been completed, the facility will still need to prepare an MDS as completely as possible for the RUG-III Classification and Medicare payment purposes. Otherwise, the days will be paid at the default rate. The Assessment Reference Date must also be adjusted to no later than the date of discharge.

+Grace Days: A specific number of grace days (i.e., days that can be added to the Medicare assessment schedule without penalty) are allowed for setting the Assessment Reference Date (ARD) for each scheduled Medicare assessment.

The Medicare assessment schedule includes a 5-Day, 14-Day, 30-Day, 60-Day and 90-Day assessment. The first day of Medicare Part A coverage is considered Day 1. In most cases, the first day of Medicare Part A eligibility is also the date of admission. However, there are situations where the Medicare beneficiary may only become eligible for Part A services at a later date. See Section 2.9 for more detailed information.

Assessments must also be completed whenever there is a significant change in clinical status or when all therapies are discontinued for a beneficiary who is classified in a RUG-III Rehabilitation Plus Extensive Services or Rehabilitation group, and that beneficiary continues to require skilled services.

A Readmission/Return assessment must be completed when a beneficiary who was receiving Part A SNF-level services is hospitalized and returns to the SNF and continues to receive Part A SNF-level services.

Assessments performed solely for Medicare payment purposes must be completed within 14 days of the Assessment Reference Date (ARD). The Assessment Reference Date establishes a common reference end-point for all items. The Assessment Reference Date is described in detail in Chapter 3. Nursing facility staff should make every effort to complete assessments in a timely

MEDICARE MDS ASSESSMENT SCHEDULE FOR SNFs

Codes for Assessments Required for Medicare	Assessment Reference Date (ARD) Can be set on any of following days	GRACE PERIOD DAYS ARD can also be set on these days	BILLING CYCLE Used by the business office	SPECIAL COMMENT
5 DAY AA8b = 1 AND Readmission/ Return AA8b = 5	Days 1-5	6-8	Set payment rate for Days 1-14	• If a resident transfers or expires before the Medicare 5-Day assessment is finished, prepare an MDS as completely as possible for the RUG Classification and proper Medicare payment, or bill at the default rate. • RAPS must be completed only if the Medicare 5-Day assessment is dually-coded as an Admission assessment or SCSA.
14 Day AA8b = 7	Days 11-14	15-19	Set payment rate for Days 15-30	• RAPs must be completed only if the 14-Day assessment was dually coded as an Admission or Significant Change in Status assessment. • Grace period days do not apply when RAPs are required on a dually coded assessment, e.g., Admission assessment.
30 Day AA8b = 2	Days 21-29	30-34	Set payment rate for Days 31-60	
60 Day AA8b = 3	Days 50-59	60-64	Set payment rate for Days 61-90	
90 Day AA8b = 4	Days 80-89	90-94	Set payment rate for Days 91-100	• Be careful when using grace days for a Medicare 90-Day assessment. The completion date of the Quarterly (R2b) must be no more than 92 days after the R2b of the prior OBRA assessment.
Other Medicare Required Assessment (OMRA)	• 8 - 10 days after all therapy (PT, OT, ST) services are discontinued and resident continues to require skilled care. • The first non-therapy day counts as day 1.	N/A	Set payment rate effective with the ARD	• Not required if the resident has been determined to no longer meet Medicare skilled level of care. • Establishes a new non-therapy RUG Classification. • Not required if the resident is dis-charged from Medicare prior to day 8. • Not required if not previously in a RUG-III Rehabilitation Plus Extensive Services or Rehabilitation group
Significant Change in Status Assessment (SCSA)	Completed by the end of the 14th calendar day following determination that a significant change has occurred.	N/A	Set payment rate effective with the ARD	• Could establish a new RUG Classification and remains effective until the next assessment is completed.

***NOTE:** Significant Correction assessments are not required for Medicare assessments that have not been combined with an OBRA assessment. See Chapter 5 for detailed instructions on the correction process.

4. **Medicare 90-Day Assessment** - Medicare assessment that must have an ARD (Item A3a) established between days 80-89 of the SNF stay. The ARD (Item A3a) can be extended to day 94 if using the designated "Grace Days." The 90-Day Medicare assessment must be completed (Item R2b) within 14 days of the ARD. The 90-Day assessment authorizes payment from days 91 through 100 of the stay, or as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b). (NOTE: When combined with an OBRA Quarterly assessment, see Section 2.2).

5. **Medicare Readmission/Return Assessment** - Medicare assessment that is completed when a resident whose stay was being reimbursed by Medicare Part A was hospitalized, discharged, and later readmitted to the SNF from the hospital. The Readmission/Return assessment, like the 5-Day assessment, must have an ARD (Item A3a) established between days 1-8 of the return. The Readmission/Return assessment must be completed (Item R2b) within 14 days of the ARD. The Readmission/Return assessment restarts the Medicare schedule and the next required assessment would be the Medicare 14-Day assessment. The MDS records must be submitted electronically, and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b).

6. **Other State-Required Assessment – This assessment is not used for Medicare purposes.** In some cases, States have established assessment requirements in addition to the OBRA and Medicare assessments. Contact your RAI Coordinator for State specific requirements.

7. **Medicare 14-Day Assessment** - Medicare assessment that must have an ARD (Item A3a) established between days 11-14 of the SNF stay or as long as the resident remains eligible for Part A SNF-level services. The ARD (Item A3a) can be extended to day 19 if using the designated "Grace Days." The 14-Day assessment must be completed (Item R2b) within 14 days of the ARD. The 14-Day assessment authorizes payment from days 15 through 30 of the stay, or as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b). If combined with the Admission assessment, then the assessment must be completed at VB2 by day 14 of admission. (NOTE: When combined with an OBRA Admission assessment, see instructions in Sections 2.2 and 2.8.)

8. **Other Medicare-Required Assessment** - The OMRA is completed only if the resident was in a RUG-III Rehabilitation Plus Extensive Services or Rehabilitation Classification and will continue to need Part A SNF-level services after the discontinuation of therapy. The last day in which therapy treatment was furnished is day zero. The OMRA ARD (Item A3a) must be set on day eight, nine, or ten after all rehabilitation therapies have been discontinued. The OMRA must be completed (Item R2b) within 14 days of the ARD. The OMRA will establish a new non-therapy RUG-III group and Medicare payment rate. The MDS records must be submitted electronically, and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b). If the OMRA falls in the assessment window of a regularly schedule Medicare assessment, code the assessment as an OMRA to affect the change in payment status.

2.8 Combining the RAI OBRA Schedule with the Medicare Schedule for SNFs

SNF providers are required to meet two assessment standards in a Medicare certified facility:

- The OBRA standards, requiring comprehensive assessments on admission, annually, when a significant change in status occurs or when a Significant Correction of a Prior Full assessment is required. Quarterly assessments are also required on the form designated by the State. These assessments are designated by the reason selected in AA8a, Primary Reason for Assessment.

- The Medicare standards, requiring assessments for payment for a resident in a Medicare Part A stay at 5-day, 14-day, 30-day, 60-day and 90-day time frames. An OMRA assessment must also be completed when a resident who was in a RUG-III Rehabilitation Plus Extensive Services or Rehabilitation Classification, had all therapies discontinued, and continues a Part A stay due to other skilled needs. These assessments are designated by the reason selected in AA8b, codes for assessments required for Medicare or the State. If the assessment is completed only for Medicare (AA8a = 00), then either the full MDS or MPAF form can be used.

When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements. When combining the OBRA and Medicare assessments, the most stringent requirement for MDS completion must be met. For example, an Admission assessment, including RAPs, must be completed within the first 14 days of the resident's stay. The requirements for Medicare specify that facilities must complete two assessments for each resident in a Medicare covered Part A stay – a 5-Day and a 14-Day.

There is no need to complete three separate assessments: the Admission assessment may be combined with either the 5-Day (AA8a = 01, AA8b = 1) or the 14-Day (AA8a = 01, AA8b = 7). However, the Admission assessment would have to be a comprehensive assessment with RAPs, not the shorter form that may be completed for Medicare assessments. The other assessment completed in the 14-day period solely for Medicare would be done using either the full MDS or the optional MPAF form (AA8a = 00, AA8b = 1 or 7 as applicable).

The nursing facility must be very careful in selecting the ARD for an Admission assessment combined with a 14-Day Medicare assessment. For the admission standard, the ARD must be set between Days 1 to 14. For Medicare, the ARD must be set between Days 11 and 14, but the regulation allows grace days up to Day 19. However, when combining a 14-Day Medicare assessment with the Admission assessment, grace days are not allowed. To assure, in this situation, that the assessment meets both standards, an ARD between Days 11 and 14 would have to be chosen.

Any OBRA assessment and any Medicare assessment may be combined in this way as long as the ARD and completion date (R2b or VB2) meet both requirements, and the most stringent completion timeframe requirement is met. For example, often the Quarterly assessment and the 90-Day Medicare assessment are due in the same time period. The facility must assure that the completion date (R2b) will occur within 92 days of the R2b of the previous comprehensive or Quarterly

window, the SCSA can be combined with a regularly scheduled Medicare assessment. If the SCSA is not within a Medicare assessment window, the Medicare reason for assessment should be coded as AA8a = 3 and AA8b = 8, Other Medicare Required assessment.

Physician Hold Occurs

If a physician hold occurs or 30 days has elapsed since a level of care change, the nursing facility provider will start the Medicare assessment schedule on the first day that Part A SNF-level services started. An example of a physician hold could occur when a resident is admitted to the nursing facility for rehabilitation services but is not ready for weight-bearing exercises. The physician will write an order to start therapy when the resident is able to do weight bearing. Once the resident is able to start the therapy, the Medicare Part A stay begins, and the Medicare 5-Day assessment will be completed. Day "1" of the stay will be the first day that the resident is able to start therapy services.

Combining Assessments

Significant Change in Status Assessment (SCSA) or the Other Medicare Required Assessment (OMRA) may be combined with the regularly scheduled Medicare assessments. If the Medicare assessment window coincides with the SCSA assessment, a single assessment may be coded as both a regularly scheduled assessment (e.g., 5-Day, 14-Day, 30-Day, 60-Day, or 90-Day) and an SCSA. If the Assessment Reference Date of an OMRA coincides with a regularly scheduled Medicare assessment, it is coded only as the OMRA. For billing purposes, it is identified as an OMRA replacing a 14-Day, 30-Day, 60-Day or 90-Day.

Currently there is no way to code that a SCSA performed outside the assessment window is a Medicare assessment. Until this problem can be corrected, code AA8a = 3 to show the SCSA and AA8b = 8 to indicate that the record is a Medicare assessment. This procedure is an exception to the rule that OMRAs are performed only to show discontinuation of therapy for residents in a RUG-III Rehabilitation Plus Extensive Services or Rehabilitation Classification. In some circumstances, an SCSA can be used as an OMRA and a scheduled Medicare assessment.

Non-Compliance with the Assessment Schedule

According to the Code of Federal Regulation (CFR) section 413.343, assessments that fail to comply with the assessment schedule will be paid at the default rate. Frequent early or late assessment scheduling practices may result in onsite review.

Early Assessment

An assessment should be completed according to the designated Medicare assessment schedule. If an assessment is performed earlier than the schedule indicates (the ARD is not in the defined window), the provider will be paid at the default rate for the number of days the assessment was out of compliance. For example, a Medicare-required 14-Day assessment with an ARD of day 10 (1 day early) would be paid at the default rate for the first day of the payment period that begins on day 15.

Recommended Approach for Becoming Familiar with the MDS (continued)

- Make notations next to any section(s) of this Manual you have questions about. Be prepared to discuss these issues during any formal training program you attend, or contact your State RAI Coordinator (see Appendix B).

(C) **In a second review of this chapter, focus on issues that seemed to you to be more difficult, problematic, or unfamiliar during the first pass.** Make notes on the MDS of issues that warrant attention.

(D) **The third chapter review may occur during the formal MDS training program at your facility.** It will provide you with another opportunity to review the material in this chapter. If you have questions, raise them during the training session.

(E) **Future use of information in this chapter:**

- Keep this chapter at hand during the assessment process.
- Where necessary, review the intent of each item in question.
- This Manual is the primary source of information for completing an assessment. Use it to increase the accuracy of your assessments.
- Check the MDS 2.0 web site regularly for updates at:
  http://cms.hhs.gov/quality/mds20

T3. Case Mix Group

Intent: Records the RUG-III Classification calculated from the facility software.

a. **Medicare**
The software calculated RUG-III Classification for the Medicare program using the 53 Group Version 5.2. The first three characters entered in the boxes represent one of the 53 RUG-III groups. The last two numbers are an indicator of the version of the RUG-III Classification system. Currently, this version is **07**. This **07** comes directly from the software and will appear on every assessment.

b. **State**
The software calculated RUG-III Classification for the State case mix field using the State-specified RUG-III Classification system. For states using the RUG-III Classification system for case mix reimbursement, this item may be required. States have the option of using either the 34 or 44 RUG-III Classification systems, or a different version of the RUG-III Classification system. The first three characters entered in the boxes represent one of the RUG-III groups. This could vary from the Medicare case mix field if the state is using the 34 RUG-III Classification system. The last two numbers may vary depending on the version of the RUG-III Classification system specified in the state. Please contact your State representatives for your State requirements.

SECTION U.
MEDICATIONS (7-day look back)

PLEASE NOTE: This section is not required by CMS. Some states have required completion of Section U. Please contact your State RAI Coordinator for State-specific instructions.

Nursing facility residents are highly susceptible to adverse drug reactions and drug interactions. Polypharmacy is the use of two or more medications for no apparent reasons or for the same purpose. Polypharmacy also occurs when a medication is used to treat an adverse reaction from another medication. Polypharmacy can occur in nursing facilities when there is no regular and careful monitoring of residents' prescribed medications.

Intent: This section will assist staff in identifying potential problems related to polypharmacy, drug reactions and interactions. Further, this section can also help staff to identify potential physical and emotional problems a resident may be experiencing. For example, reviewing and documenting the frequency a resident uses a PRN pain medication, sleeping medication, or laxative may lead the interdisciplinary team to do further assessment related to underlying causes associated with the use of PRN medications. Many of the RAPs and Triggers refer to assessment of medications in which this section would be very helpful.

SECTION W.
SUPPLEMENTAL ITEMS

W1. National Provider Identifier (NPI)

Intent: To record the NPI of the facility.

Definition: The NPI is a unique identifier for health care providers of health care services, supplies, and equipment. The HIPAA legislation required the Secretary of the Department of Health and Human Services (HHS) to establish a standard unique identifier for health care providers. The National Plan and Provider Enumeration System (NPPES), developed by CMS, has begun assigning NPIs to health care providers.

Process: After the NPPES assigns an NPI to a provider, like a nursing facility, the NPI applies to the facility for all of its residents.

Coding: When the NPI is available, enter the 10-digit NPI in the spaces provided. The NPI has no embedded dashes or spaces. Recheck the number to ensure you have entered the 10 digits correctly. The facility is encouraged to begin using this number once it has obtained it.

W2. Influenza Immunization

Intent: To determine the rate of vaccination and causes for non-vaccination.

Section W2 must be completed for all residents on all assessment types (OBRA and/or PPS) with Assessment Reference Dates and all discharge tracking forms with Discharge Dates from October 1 through June 30. Discharge tracking forms are included in order to capture flu vaccines administered to residents whose flu vaccines were not captured on an MDS assessment.

Although flu season currently is defined as October 1 through March 31, assessments with an ARD and discharges with a discharge date through June 30 are included in order to capture any record that provides the only report of a vaccination received during the flu season.

> **Example:** A flu vaccine is administered to a resident in March, not within the window of an MDS assessment. Extending the date for completing W2 to June 30 provides the facility the ability to capture that flu vaccine on the next Quarterly, even if it is not due for another 92 days or on a discharge before the Quarterly is due.

Process: **Review the resident's medical record and interview the resident or responsible party/legal guardian to determine Influenza vaccination status during this year's flu season, defined as October 1 through March 31. Use the following steps:**

- **Step 1.** Review the resident's medical record to determine whether an Influenza vaccination was received during the flu season. If vaccination status is unknown, proceed to the next step.

- **Step 2.** Ask the resident if he/she received a dose of Influenza vaccine outside of the facility for this year's flu season. If vaccination status is still unknown, proceed to the next step.

- **Step 3.** If the resident is unable to answer, then ask the same question of the responsible party/legal guardian. If vaccination status is still unknown, proceed to the next step.

- **Step 4.** If vaccine status cannot be determined, administer the vaccination to the resident according to standards of clinical practice.

The CDC has evaluated inactivated Influenza vaccine co-administration with the pneumococcal polysaccharide vaccine systematically among adults. Simultaneous vaccine administration is safe when administered by a separate injection in the opposite arm[2,3]. If the resident is an amputee or if intramuscular injections are contraindicated in the upper extremities, administer the vaccine(s) according to standards of clinical practice.

Coding: **W2a**

Enter **"0" for a 'No' response and proceed to item W2b**

- If the resident did not receive the Influenza vaccine in this facility from October 1 – March 31.

  Example: Mrs. J. received the Influenza vaccine in January 2005. The ARD of this assessment is October 2005. The facility has not yet administered the Influenza vaccine for the current flu season. W2a would be coded "0", No.

Enter **"1" for a 'Yes' response and proceed to item W3**

- If the ARD of this assessment or the discharge date of this discharge tracking form is from January 1 through June 30,

include Influenza vaccine administered in the facility from October 1 of last year through March 31 of the current year.

Example: Mrs. T. received the Influenza vaccine in November 2004. The ARD of this assessment is February 2005. Include the November 2004 vaccination on this assessment and code W2a "1", Yes.

- If the ARD of this assessment or the discharge date of this discharge tracking form is on or after October 1, include the Influenza vaccine administered in the facility on or after October 1 of the current year.

Example: Mr. C received the Influenza vaccine in October 2005. The ARD of this assessment is December 2005. Include the October 2005 vaccination on this assessment and code W2a "1", Yes.

Skip item W2 and go to item W3

- If the ARD of this assessment or the discharge date of this discharge tracking form is from July 1 through September 30.

Example: Mr. P. received the Influenza vaccine in February 2005. The ARD of this assessment is in August 2005. Skip this item and go to item W3.

W2b

If the resident has not received the Influenza vaccine in the facility, code the reason from the following list:

1. Not in facility during this year's flu season - Resident not in the facility from October 1 – March 31.

2. Received outside of this facility - Includes Influenza vaccinations administered from October 1 through March 31 in any other setting (e.g. physician office, health fair, grocery store, hospital, fire station).

3. Not eligible – Due to contraindications including:

- allergic reaction to eggs or other vaccine component(s)
- a physician order not to immunize
- or an acute febrile illness is present; however, the resident should be vaccinated if contraindications end

4. Offered and declined – Resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the vaccine. See pages 3-36 & 37 for types of responsibility/legal guardian.

5. Not offered – Resident or responsible party/legal guardian not offered the vaccine. See pages 3-36 & 37 for types of responsibility/legal guardian.

6. Inability to obtain vaccine – Vaccine unavailable at the facility due to declared vaccine shortage; however, the resident should be vaccinated once the vaccine is received. The annual supply of inactivated Influenza vaccine and the timing of its distribution cannot be guaranteed in any year.

W3. Pneumococcal Immunization

Intent: To determine the rate of vaccination and causes for non-vaccination.

Section W3 must be completed for all residents on all assessment types (OBRA and/or PPS) and all discharge tracking forms.

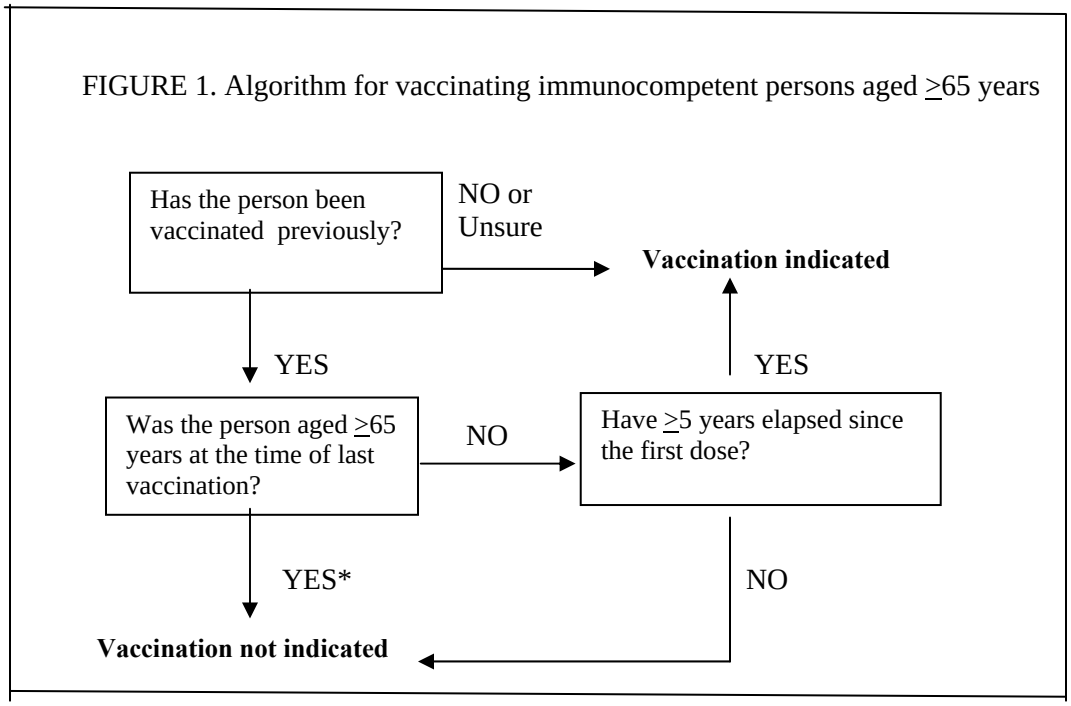
- The CDC has evaluated inactivated Influenza vaccine co-administration with the Pneumococcal Polysaccharide Vaccine (PPV) systematically among adults. Simultaneous vaccine administration is safe when administered by a separate injection in the opposite arm[2,3]. If the resident is an amputee or intramuscular injections are contraindicated in the upper extremities, administer the vaccine(s) according to clinical standards of care.

- Persons less than 65 years of age who are living in environments or social settings (e.g. nursing homes and other long-term care facilities) in which the risk for invasive pneumococcal disease or its complications is increased should receive the PPV[2].
- All adults 65 years of age or older should get the PPV. PPV is given once in a lifetime, with certain exceptions[1].

- Persons 65 years or older should be administered a second dose of vaccine (booster vaccine) if they received the first dose of vaccine more than 5 years earlier and were less than 65 years old at the time[1,2].

Note: Please refer to the following algorithm for PPV administration ONLY

Figure 1 Adopted from the CDC Recommendations and Reports. Prevention of Pneumococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR April 1997;46(RR-08);1-24.



***For any immunocompetent person who has received a dose of pneumococcal polysaccharide vaccine at age ≥65 years, revaccination is not indicated.**

1 CDC. Pneumococcal Polysaccharide Vaccine. What you need to know. Pneumococcal Vaccine Information Statement July 1997.
2 CDC. Prevention of Pneumococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR April 1997;46(RR-08);1-24.
3 Recommendations and Reports. Prevention and control of influenza. Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR May 28, 2004/ 53(RR06);1-40.

- The CDC recommends a second (booster) dose for immunocompromised persons due to[1]
  - A damaged spleen or no spleen
  - Sickle-cell disease
  - HIV infections or AIDS
  - Cancer, leukemia, lymphoma, multiple myeloma
  - Kidney failure
  - Nephrotic syndrome
  - History of an organ or bone transplant
  - Medication regimens that lowers immunity (such as chemotherapy or long-term steroids)

  When any of the above conditions are present, persons older than 10 years old (including those 65 years of age and older) should get the second (booster) dose 5 years after the first dose. Children 10 years old and younger may get this second (booster) dose 3 years after the first dose.

Process: **Review the resident's medical record and interview resident or responsible party/legal guardian to determine PPV status, using the following steps.**

- **Step 1.** Review the resident's medical record to determine whether PPV has been received. If vaccination status is unknown, proceed to the next step.

- **Step 2.** Ask the resident if he/she received a PPV. If vaccination status is still unknown, proceed to the next step.

- **Step 3.** If the resident is unable to answer, ask the same question of a responsible party/legal guardian. If vaccination status is still unknown, proceed to the next step. See pages 3-36 & 37 for types of responsibility/legal guardian.

- **Step 4.** If vaccination status cannot be determined, administer the appropriate vaccine to the resident, according to the standards of clinical practice.

Coding: **W3a**

Enter "0" for a 'No' response and proceed to item W3b

- If the resident's PPV status is not up to date

Enter "1" for a 'Yes' response and skip item W3b

- If the resident's PPV status is up to date

W3b

If the resident has not received a PPV, code the reason from the following list:

1. Not eligible – Due to contraindications including:

- allergic reaction to vaccine component(s)
- a physician order not to immunize
- an acute febrile illness is present; however, the resident should be vaccinated after contraindications end

2. Offered and declined – Resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the vaccine. See pages 3-36 & 37 for types of responsibility/legal guardian.

3. Not offered - Resident or responsible party/legal guardian were not offered the vaccine. See pages 3-36 & 37 for types of responsibility/legal guardian.